

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
OFFICE OF FINANCIAL AND INSURANCE REGULATION
Before the Commissioner of Financial and Insurance Regulation

In the matter of

XXXXXX

Petitioner

v

File No. 123094-001

Blue Cross Blue Shield of Michigan
Respondent

Issued and entered
this 17th day of January 2012
by R. Kevin Clinton
Commissioner

ORDER

I. PROCEDURAL BACKGROUND

On August 26, 2011, XXXXX (Petitioner) filed a request with the Commissioner of Financial and Insurance Regulation for an external review under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq.* The Commissioner reviewed the request and accepted it on September 2, 2011.

The Commissioner notified Blue Cross Blue Shield of Michigan (BCBSM) of the external review and requested the information used in making its adverse determination. The Commissioner received BCBSM's response on September 14, 2011.

The issue in this external review can be decided by a contractual analysis. The contract that defines the Petitioner's health care benefits is the BCBSM *Flexible Blue II Individual Market Certificate* (the certificate). The Commissioner reviews contractual issues pursuant to MCL 550.1911(7). This matter does not require a medical opinion from an independent review organization.

II. FACTUAL BACKGROUND

On January 29, 2011, the Petitioner experienced jaw pain and went to the emergency room of XXXXX XXXXX Hospital for treatment. BCBSM denied coverage for the emergency

medical services, saying the Petitioner's condition did not require emergency treatment.

The Petitioner appealed BCBSM's denial through its internal grievance process. BCBSM held a managerial level conference on May 10, 2011, and issued a final adverse determination dated July 29, 2011, upholding its denial.

III. ISSUE

Did BCBSM correctly deny coverage for the Petitioner's January 29, 2011, emergency services?

IV. ANALYSIS

Petitioner's Argument

The Petitioner says that she went to the emergency room because "I was having jaw pain which is a symptom of heart attack in women. I did not enter for dental care."

She believes BCBSM should cover the emergency room services she received on January 29, 2011.

BCBSM's Argument

In its final adverse determination, BCBSM told the Petitioner:

As explained on Pages 3.20 and 4.7 of the certificate, coverage is provided for the initial examination and treatment of a medical emergency or accidental injury. A medical emergency is defined on Page 8.16 as "A condition that occurs suddenly and unexpectedly. This condition could result in serious bodily harm or threaten life unless treated immediately. This is not a condition caused by an accidental injury."

Our medical consultants reviewed the records for your services. Based on that review, it was determined that pain in the left temporomandibular joint with jaw movement and eating is not a medical emergency and can be treated in a lesser setting. Therefore, we are unable to approve payment for the emergency room services and you remain liable for the charges.

BCBSM notes that the Petitioner had pain in the left temporomandibular joint (TMJ) that worsened with jaw movement and eating. BCBSM argues that TMJ syndrome does not require emergency medical treatment and could have been treated in a lesser setting. BCBSM also says that the Petitioner did not submit any medical documentation to show that she had a history of cardiac conditions.

BCBSM maintains that no benefits are allowed for the emergency room care.

Commissioner's Review

The certificate, under "Outpatient Hospital Services That Are Payable" on p. 3.20, covers emergency room services for medical emergencies:

- Emergency room services are payable when provided for the initial examination and treatment of medical emergencies or accidental injuries.

"Medical emergency" is defined on p. 8.16 of the certificate:

A condition that occurs suddenly and unexpectedly. This condition could result in serious bodily harm or threaten life unless treated immediately. This is not a condition caused by an accidental injury.

In reviewing this case, the Commissioner relies not only on the language of the certificate but also relevant statutory provisions. BCBSM is a health care corporation organized under and subject to the Nonprofit Health Care Corporation Reform Act (NHCCRA), MCL 550.1101 *et seq.* Section 418 of NHCCRA (MCL 550.1418) is also pertinent in this analysis:

(1) A health care corporation certificate that provides coverage for emergency health services shall provide coverage for medically necessary services provided to a member for the sudden onset of a medical condition that manifests itself by signs and symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in serious jeopardy to the individual's health or to a pregnancy in the case of a pregnant woman, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part. A health care corporation shall not require a physician to transfer a patient before the physician determines that the patient has reached the point of stabilization. A health care corporation shall not deny payment for emergency health services up to the point of stabilization provided to a member under this subsection because of either of the following:

- (a) The final diagnosis.
- (b) Prior authorization was not given by the health care corporation before emergency health services were provided.

(2) As used in this section, "stabilization" means the point at which no material deterioration of a condition is likely, within reasonable medical probability, to result from or occur during transfer of the patient.

Under Section 418, emergency care is covered if the sudden onset of a condition produced “signs and symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in serious jeopardy to the individual's health” even if the final diagnosis determined that the condition was not truly an emergency. In this case, the final diagnosis was “TMJ syndrome” and the Petitioner was discharged with a prescription for ibuprofen, a nonsteroidal anti-inflammatory drug.

The notes from the emergency room visit on January 29, 2011, relate the following complaint and history:

The patient presents with jaw pain and Patient awoke this AM with left jaw pain that is worse when she moves her jaw up and down, side to side and when she ate this AM. Patient denies CP, sob, trauma. Patient points to the TMJ joint on the left. The onset was this AM. The course/duration of symptoms is constant. Location: Left jaw TMJ. The character of symptoms is "pain" and achy. The degree at present is minimal. Exacerbating factors consist of movement palpation. The relieving factor is none. Risk factors consist of none. Prior episodes: none. Therapy today: none. Associated symptoms: denies fever, denies chills, denies nausea, denies vomiting, denies headache, denies altered vision, denies rash, denies change in voice, denies dyspnea denies rhinorrhea, denies nasal congestion, denies cough, denies ear pain, denies sore throat, denies difficulty swallowing, denies dental pain, denies tongue swelling, denies chest pain, denies neck pain and denies back pain. Associated injury none.

The sole presenting complaint was jaw pain. There was nothing in the emergency room notes to show that the Petitioner expressed concern at the time that she was having a heart attack. Further, the emergency room notes reflect that the Petitioner reported a pain score of 2, not a severe level.

Given the presenting complaint, the lack of other symptoms, and the absence of any history of cardiac problems, the Commissioner concludes that it was not reasonable for the Petitioner to believe that there would be serious jeopardy to her health if she did not seek immediate emergency treatment for her jaw pain.

V. ORDER

BCBSM's January 29, 2011, final adverse determination is upheld. BCBSM is not required to cover the Petitioner's emergency room visit on January 29, 2011.

This is a final decision of an administrative agency. Under MCL 550.1915, any person aggrieved by this Order may seek judicial review no later than sixty days from the date of this Order in the circuit court for the county where the covered person resides or in the circuit court of

Ingham County. A copy of the petition for judicial review should be sent to the Commissioner of Financial and Insurance Regulation, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.

R. Kevin Clinton
Commissioner